June 27, 2001

Senator Max Baucus
Senator Charles Grassley
Committee on Finance
United States Senate

Dear Senators Baucus and Grassley,

Thank you for inviting me to speak before the Committee concerning my participation in the General Accounting Office's investigation of health care consultants that advise physicians and medical groups how to enhance revenues for their practices and avoid audits.

Pressures to contain and reduce the costs of providing health care have had a major impact on the practice of medicine, and will increasingly shape the way care is provided as our population ages. The costs of fraud and abuse are of additional concern as a substantial portion of our global health care spending is wasted. I am a physician specializing in internal medicine and geriatric medicine, and have practiced in both managed care and fee-for-service environments. When asked by GAO to assist in the investigation of consulting companies that market themselves to physicians and medical groups regarding revenue-enhancement and compliance with anti-fraud measures, I was intrigued because of a prior experience with such an organization.

While employed as a faculty member of the University of California, Davis School of Medicine in early 1998, I attended a "mandatory" seminar about coding and billing for faculty outpatient medical care presented by consultants to the medical center. The seminar was arranged in anticipation of a government audit of billing practices in academic institutions. The medical center at the University of Pennsylvania had recently been audited and been made to pay fines of approximately $40 million; the UC system was preparing for the potential of a similar action by the government within UC.

Most of the faculty's outpatient clinical activities were conducted for the purposes of teaching as well as providing patient care. A medical student or physician-trainee (intern, resident or fellow) would see the patient initially, perform a history and physical examination (usually quite exhaustive, as the trainee was still learning what was important), and then present the findings to an attending faculty member. Discussion and teaching would ensue, followed by a joint visit with the trainee and faculty member. The attending faculty was responsible for determining the billing code for the visit.

The purpose of the coding seminar was to educate the faculty about how to accurately bill for clinic visits. Of particular importance was the need to document that the faculty member had validated all of the information that had been gathered by the trainee. To that end, new encounter forms for clinic visits were being rolled out to aid the faculty and the trainees in documenting what information had been collected during the course of the visit in order to justify the (higher) billing code. It was made clear to us that the primary purpose of the new forms was to enable billing at a higher reimbursement level.

What I and the other faculty members with whom I discussed the seminar afterward took away from this was that we were to "game the system" – that is, bill at a higher level because the trainee had gathered and documented information sufficient to justify the higher billing codes, regardless of medical necessity, in order to bring in more revenue for the medical center.

This same theme, that documentation is the key to higher billing codes (and thus higher revenues), permeated the seminars and workshops that I attended with the GAO during the course of this investigation. Similarly, regarding compliance plans, "audit-proofing" your practice was simple if you adhered to a formulaic documentation system designed to ensure that the needed elements for billing at a higher level were recorded in the patient's chart.

On the face of it, it seems reasonable that higher reimbursement is given for more complicated physician work – this is the basis for the Evaluation and Management[1] system of payments to physicians. However, what is missing from the schema is a defined way to determine that a given quantity of work was medically necessary. The information presented to us at the seminars did not include any method of documenting or ensuring that the services billed for were medically necessary. Rather, it was implicit, as in the sample case of billing at a high level for a visit by a 14-year-old with a sore throat by adding documentation, that the medical necessity would not be questioned, or that if it was, the documentation would support that the service provided and billed for was reasonable and prudent.

One of the consultants we contacted advocated incorporating "ancillary" services, such as offering Holter monitors for cardiac patients and peripheral nerve testing for diabetics, into "our practice" in order to enhance revenues. The use of extended service codes (based on time, resulting in higher reimbursement) for Alzheimer's patients was also recommended, since obviously it would take longer to gather information from a patient with dementia. I, as the primary beneficiary of such enhancements, would then be able to go out and buy that new Lexus or that Kincaid painting I had my eyes on! Justifying the performance of the testing was easy if we simply documented the "right" diagnosis codes, independent of the actual medical necessity for the procedure. This consultant advertises on his Internet web site that he can increase physician practice revenues by "$10,000 per month" through the generation and performance of such tests in the physician's office. One of the services offered includes an on-site visit to the practice and assistance with setting up the ancillary services, with a percentage of the revenues generated to be paid to the consultant in the process.

[1] "Evaluation and management" services refer to the work that physicians do that does not involve a procedure. Traditionally and to this day, doctors are paid more for procedures than for "mental work". The current system to determine payment for evaluation and management services was developed in order to compensate physicians more when they do more mental work, i.e. the patient's problems are more numerous, more complex, there are more treatment options or diagnostic decisions to be made, and there is more risk to the patient involved in terms of serious outcomes from the problem(s) at hand.

In conclusion, the information we gathered in the course of our investigation suggests that the consultants marketing to and attracting physicians and physician groups advocate enhancing revenues in an “audit-proof” fashion through systematic documentation efforts, regardless of medical necessity. The timbre of these seminars was consistent with my prior experience in an academic medical center. In spite of cost reduction and containment pressures, providers of health care to Medicare beneficiaries continue to practice in a climate and culture where maximizing reimbursement and avoiding audits are emphasized. In my opinion, improving efforts to reduce fraud and abuse should include increasing the focus on issues of medical necessity.

Thank you, and I respectfully request that you make my statement part of the official hearing record.

Kathryn Locatell, MD